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'Mind and Body' - Early intervention for young people at risk of self-harm

Evidence suggests that self-harming behaviours within the adolescent population are increasing. In the past decade, the number of young people admitted to hospital due to self-harm has risen by 68%. (Young Minds, 2016). It is estimated that between 8% and 15% of adolescents self-harm (NICE, 2013; Young Minds, 2016); however, only 1 in 8 of those in the community present themselves at hospital for assessment or treatment (Hawton, Saunders and O'Connor, 2012). It is likely, therefore, that the prevalence of self-harm in adolescence is underestimated and many of those that are actively self-harming or experiencing thoughts to self-harm may not be receiving support, treatment or even acknowledgement.

Alongside this, research has shown that Child and Adolescent Mental Health services (CAMHS) are more in demand than ever before. Between 2013 and 2015, referrals to CAMHS increased by 64%. (Frith, 2016) When combined with inadequate funding, the demand represented by these figures becomes unmanageable. In order to prioritise those most at risk, thresholds for assessment and treatment are driven up. As a result, on average, 23% of children and adolescents referred to CAMHS are turned away (Frith, 2016).

This lack of capacity is reportedly then felt within other agencies. A recent survey suggested that 65% of Headteachers feel that getting support from CAMHS is a struggle (Frith, 2016). In addition, the average maximum waiting time for young people to access other mental health provisions is 26 weeks (Frith, 2016). As a result, the options for adolescents requiring support for self-harm are limited and, at times, inaccessible.

The Inception of 'Mind and Body'

'Mind and Body' is a multi-component programme for young people who are involved in, or vulnerable to, self-harming behaviours. The focus is on exploring thoughts and actions in relation to emotional wellbeing, but also aims to provide participants with strategies to reduce other risk-taking behaviours, such as drug and alcohol use, unplanned or unprotected sex and offending.

The 'Mind and Body' programme has been developed in conjunction with young people and professionals, and draws on Addaction's experience of delivering enhanced early intervention with young people around substance misuse and wider risk-taking behaviours. Following an initial pilot in Canterbury, an expanded 'Mind and Body' programme has now been commissioned across Kent, and has been funded for delivery in Cornwall and Lancashire. An evaluation of the programme will be undertaken by a research team from the University of Bath, examining data across each of these sites.

'Mind and Body' contains many of the core components of the 'RisKit' programme, which has been successfully delivered by specialist early intervention workers from Addaction (and previously KCA Young Persons' Service) since 2009. 'Mind and Body' is primarily targeted at young people aged between 14 and 17 years old who would not meet the thresholds of specialist mental health services, but who are identified as being vulnerable to specified self-harming behaviours. These include a wide range of behaviours such as: self-injury (e.g. cutting, bruising, self-poisoning); physical risk-taking

(e.g. deliberately walking into traffic); and restricting diet (as a self-harming behaviour, rather than a symptom of an eating disorder).

There are various components to the programme: one-to-one motivational interviews and assessments (separate from other group members); therapeutic group work sessions exploring thoughts, behaviours, life skills and risk reduction strategies; and the creation of links between participants and outside agencies who can continue to support them after the programme concludes.

Young people are identified for the programme through the completion of a screening survey, the results of which indicate who may be most appropriate to take part. These individuals are then invited to attend a pre-programme one-to-one meeting with an Addaction practitioner, where their level of need is assessed and the therapeutic process begins.

Key to the success of 'Mind and Body' has been the group-work sessions based around discussion. Within them, young people are given the opportunity to explore topics, thoughts and behaviours that many of them have never felt able to talk through before.

Practitioners have witnessed this to be a liberating experience for young people, with feelings of isolation greatly reduced and, perhaps most importantly, reportedly enjoyable to take part in.

Outcomes from the initial Canterbury-based Pilot Programme

In 2014, 'Mind and Body' was commissioned by Canterbury City Council to target young people involved in, or deemed especially vulnerable to, self-harming behaviours. This followed requests from GPs about the lack of service provision for young people who self-harmed but did not meet the thresholds of specialist mental health services.

Students taking part in the programme came from five schools in the Canterbury district, including a mix of comprehensive and grammar schools. The programmes were run by workers from Addaction, experienced in delivering therapeutic group work interventions.

Participant information

49 young people took part in the programme. Ages and gender can be broken down (see Table 1 next column):

Table 1. Numbers involved in the Canterbury-based Pilot Programme

	12 years	13 years	14 years	15 years	16 years	TOTAL
Female	3	6	16	17	2	**44**
Male	-	-	1	2	2	**5**
TOTAL	3	6	17	19	4	**49**

Whilst the programme aimed to target young people from Year 9 and above, there were a small number of participants younger than this. They were assessed as having a lower level of need, but appropriate to attend sessions for information, advice and support around self-esteem and resilience.

Group allocation was carefully considered, ensuring participants' ages, presentations and levels of need were appropriate. Participants only joined groups where others were of the same age, or up to one school year apart. The dynamics of each group were carefully considered by facilitators and relevant school staff, in order to minimise any difficulties that may have arisen.

There were more female than male participants. This was partly due to the fact that three of the groups came from a girls' grammar, whereas the other schools were all co-educational. Furthermore, without the development of a screening tool (due to the limited timeframe and capacity for the pilot), referrals instead came from the school pastoral teams. It is possible that male pupils were less inclined to talk openly about self-harm and emotional wellbeing; and therefore were not identified as relevant for the programme.

Of the 49 young people that commenced the 'Mind and Body' programme, 47 of these continued, giving a completion statistic of 95.9%. 2 young people opted out because they did not feel it was relevant for them to take part. In both cases, Addaction staff did not feel the young people presented with an elevated level of risk.

Outcome Measures

Outcome measures were completed at three intervals: pre (in advance of the group sessions); post (shortly after the sessions were completed); and exit (roughly three months after the sessions had finished). At each one-to-one meeting, participants were asked to complete the following outcome measures:

- Timeline Follow-Back (TFB) - this charts participant behaviours over the past 28

days, exploring self-harm in relation to thoughts and actions, as well as substance use and sexual behaviour.

- Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) - an established scaling tool designed to assess an individual's current thoughts, feelings and general wellbeing.

These measures provided the quantitative data for the evaluation of the pilot, but were also invaluable as therapeutic tools; allowing workers and participants to collaboratively explore current behaviours and their related underlying motivations.

Quantitative Data

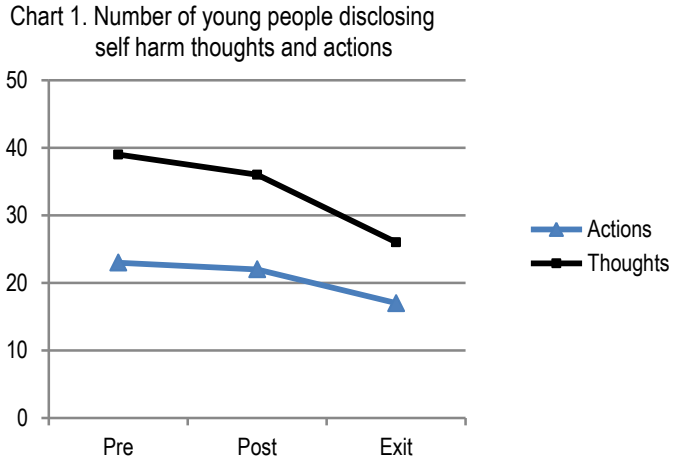


Chart 1 (above) shows, in total, 39 participants reported having thoughts to self-harm at the start of the programme. At exit, this figure had reduced to 26 participants, a reduction of 33.3%.

All participants disclosed having had historical thoughts to self-harm.

23 participants had self-harmed in the 28 days prior to their pre-programme one-to-one meeting. At the time of the exit one-to-one meetings, 17 participants had self-harmed in the previous 28 days, indicating 26.1% of those who had self-harmed had stopped at exit stage.

67.5% of participants with self-harming thoughts at the start of the programme reported a reduction in the number of days on which they experienced these at exit.

64.5% of participants who acted on self-harming thoughts at the start of the programme reported a reduction in the number of days on which they did so at exit.

Across the whole cohort at pre-programme stage there were a total of 422 days where participants had thought about self-harming. This figure fell to 207 days at exit, a reduction of 50.9%.

Across the whole cohort at pre-programme stage there were a total of 97 days where participants had self-harmed. This figure fell to 76 days at exit, a reduction of 22.6%. The majority of these 76 days were attributed to 4 participants who exhibited more entrenched self-harming behaviours. Each of these young people were referred to specialist mental health services for ongoing support, or were already engaged with them.

Where self-harming thoughts and actions did continue, participants reported that these were significantly less frequent and the severity of their self-harm had reduced.

The other risk behaviours covered by the TFB (substance use and sexual behaviours) did not transpire to be relevant topics for the vast majority of group members.

Two young people did report substance use (alcohol and cannabis); while neither was at a particularly high level of risk, both were referred for specialist treatment support from the local treatment service.

Self-Injury versus Other Behaviours

It should be noted that the definition of self-harm used in the pilot was led by the NICE (2013) guidelines, hence the data do not include behaviours such as restricting diet or substance misuse, unless specifically captured in the case of the latter. It is however important to recognise that problematic behaviours such as binge eating, purging and excessive exercise did affect several participants in a number of groups. As such, one of the findings of the pilot programme is that more information and support needs to be available to young people in relation to healthy lifestyles, nutrition and body image.

It is also important to note that several participants provided feedback about how 'Mind and Body' helped them to better manage either eating behaviours or excessive exercise. There is also evidence of attitudinal change: four young people were referred for specialist support in relation to problematic eating behaviours; all of whom had previously declined this support at the start of the programme, as they did not perceive this to be detrimental to their health.

Mental Wellbeing

The WEMWBS tool consists of 14 questions where participants score themselves between 1

and 5 in terms of their current mental wellbeing. The lowest possible score is therefore 14 with the best possible score being 70. Scores below 30 indicate a potential risk in relation to wellbeing, whilst a score of 31 - 40 is below average. 41 - 59 is the region where most of the population would be expected to score, with scores 60 and above being above average. Table 2 below shows the number of participants registering in each category:

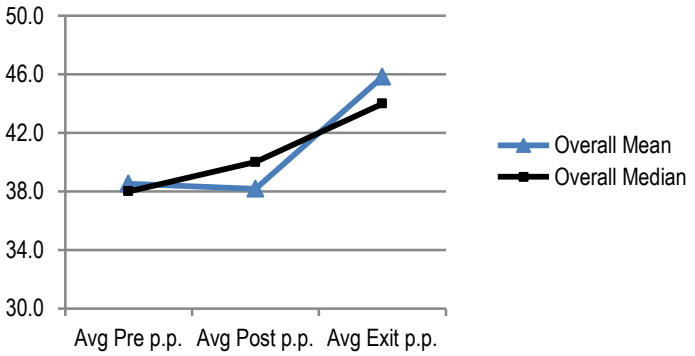
Table 2. Number of participants registering in each WEMWBS category

	14 - 30 (potential risk)	31 - 40 (below average)	41 - 59 (average)	60 - 70 (above average)
Pre	10	17	22	0
Post	10	12	20	1
Exit	4	11	20	7

The results show an upward trend as the programme progresses, with fewer participants presenting below the population average. As with the TFB scores around self-harm, it is of note that there is an improved score from post to exit. During this time, participants would not have had additional input from staff, but the life skills and coping strategies gained in group sessions are employed independently. The consistent improvement across these outcome tools as time progresses gives an indication that participants have been able to manage their thoughts, feelings and behaviours in an increasingly positive manner.

Chart 2 (below), showing the average WEMWBS score per person at each of the three intervals, highlights this greater improvement in scores as the programme progresses; the mean being pre = 38.5, post = 38.2 and exit = 45.8, and the median being pre = 38, post = 40 and exit = 44.

Chart 2. WEMWBS cohort average



Breaking this down into individual data, an overall change score of 3 or more is likely to prove greater than any measurement error, with an overall change of 8 or more equating to a score of statistical importance (Hendramoorthy, et al., 2012).

At exit stage 40.4% of participants reported an improved WEMWBS score of 8 or more, with a further 21.3% reporting a score that improved by at least 3. 78.7% of participants in total registered an improvement in their WEMWBS score.

As the quality of life of young people increases, it can be hoped that there will be a corresponding benefit to wider services in terms of reduced referrals to GPs and specialist mental health services, as well as potentially fewer admissions to Accident and Emergency departments. While these outcomes were not captured in this pilot, such data that would be explored in any future work.

Conclusions: Participant Feedback and Additional Developments

The therapeutic group work element was key in encouraging and promoting attitudinal and behavioural change. - One of the core successes of the programme was the therapeutic group element. Several participants fed back that, whilst there was some initial awkwardness, the group environment reduced feelings of isolation and helped them to realise that they were not alone. As such, all future 'Mind and Body' programmes will operate within the group setting, alongside the one-to-one meetings with practitioners at pre, post and exit stages. Support will still be accessible for those who do not feel that they can engage in a group environment, through signposting to other appropriate services.

The number of therapeutic group sessions has been increased from four to a total of eight. - Group members reported feeling that they could have benefitted further from the programme if there had been additional sessions, adding that it took time for them to get used to the group environment. As such, there will be six initial group sessions held over approximately a month's timeframe. After a period of 4-6 weeks, the group will then return for two additional post-programme sessions, where they will review their progress and explore what additional support they may need.

A screening tool has been developed to ensure that the most appropriate young people are accessing the programme. - The pilot relied on the knowledge of school staff in identifying appropriate young people for the sessions. Some relevant young people may not have been known to pastoral teams and consequently would not have received the programme. Others exhibited entrenched behaviours that present too high a risk for this programme to be the most effective intervention. Since the delivery of the pilot, we now have in place a screening tool that students complete as a way of trying to ensure the correct young people are getting support. While this is at too early a stage to draw conclusions from, the inclusion of a survey may also address the gender bias shown in the pilot. ('RisKit', which does have a screening tool, recruits a more balanced mix of male and female participants.)

Specialist training should be available to help school staff and other relevant mentors better understand self-harm and how to support young people affected by this issue. - Some participants felt that staff did not understand self-harm, which made it difficult for them to ask for support. In addition to the therapeutic sessions provided for the students, the new model enables schools receiving 'Mind and Body' to access training sessions for staff and other relevant partner agencies. Furthermore, the programme will be introduced within a school assembly, where Addaction staff will highlight the importance of talking openly about emotional wellbeing in general. As well as an overview of 'Mind and Body', the students and staff in attendance will be provided with statistics that highlight that it is not unusual for people to experience mental health issues at some stage of their life. It is expected that this will further address the stigma around mental health issues that is widely experienced.

Programmes should demonstrate clear communication with specialist services. - Open dialogue between Addaction workers and specialist mental health staff clearly benefitted those young people who required ongoing support. Where referrals were made into CAMHS, the process was straightforward and young people were seen in a timely manner. The ongoing communication between these agencies has allowed for some of the 'Mind and Body' practitioner positions in Kent to be based alongside CAMHS teams. In these instances, rather than using the screening tool to identify appropriate young people, those who have been referred to CAMHS but do not meet their criteria can instead be offered a place on a community-based 'Mind and Body' programme. It is hoped that this will relieve some of the strain on specialist services, while benefitting young people who would otherwise be lacking in support.

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